Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MILLENNIUM CHIROPRACTIC
ERIC A. VANDERWERFF, DC

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-14-2290-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "WE BELIEVE THAT OUR DOCUMENTATION IS SUFFICIENT FOR THE CARRIER TO PROCESS AND PAY THESE BILLS."

Amount in Dispute: $1,081.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2013	CPT Code 99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	$265.00	$233.86
July 15, 2013	CPT Code 97140-GP Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	$85.00	$0.00
July 18, 2013	CPT Code 98943 Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	$50.00	$0.00

July 22, 2013	CPT Code 97750-FC (14 units) Functional Capacity Evaluation (FCE)	$681.00	$0.00
TOTAL		$1,081.80	$233.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
3. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §134.1 states that in the absence of an applicable fee guideline reimbursement will be fair and reasonable.
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 15-(150)- Payer deems the information submitted does not support this level of service.
   - 59-Processed based on multiple or concurrent procedure rules.
   - 97-The benefit for this procedure is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - W3-Request for reconsideration.

Issues

1. Does the documentation support billing code 99215?
2. Is the requestor entitled to reimbursement for code 97140-GP?
3. Is the allowance of code 98943 included in the allowance of another procedure performed on the disputed date of service?
4. Is the requestor exempt from the FCE limits outlined in 28 Texas Administrative Code §134.204(g)?
5. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on July 22, 2013?

Findings

1. According to the submitted documentation the respondent denied reimbursement for code 99215 based upon reason code "15(150)."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The requestor submitted a Post-Operative Examination Report that supports billed service, reimbursement per 28 Texas Administrative Code §134.203(c) is recommended.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006

Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061, which is located in Irving, Texas; therefore, the Medicare participating amount is based on locality "Dallas, Texas".

The Medicare participating amount for code 99215 is $143.88.

Using the above formula, the Division finds the MAR is $233.86. The respondent paid $0.00. As a result, reimbursement of $233.86 is recommended

2. The respondent denied reimbursement for code 97140-59-GP based upon reason code "59." The requestor contends that "These are false denials, as the CCI Edits state the '-59' modifier is to be used when billing 97140 and a CMT (Chiropractic Manipulative Treatment), which in this case we billed."

   28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   On the disputed date of service, the requestor billed CPT codes 98943, G0283-GP, 97140-59-GP, 97110-GP and 98940.

   Per CCI edits, CPT code 97140 is a component of CPT code 98940; however, a modifier is allowed to differentiate the service. A review of the requestor's billing finds that the requestor appended modifier "59-Distinct Procedural Service" to CPT code 97140.

   Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   A review of the Patient Daily Note finds that the documentation does not support "a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." As a result, reimbursement is not recommended.

3. The respondent denied reimbursement of code 98943 based upon reason code "97."

   On the disputed date of service, the requestor billed code 98943, G0283, 97140 and 97110. Per CCI edits, CPT code 98943 is not a component of another service billed on the disputed date; therefore, the respondent's denial based upon reason code "97" is not supported.

   28 Texas Administrative Code §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." CPT code 98943 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   28 Texas Administrative Code §134.1(e)(3) states "in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

   28 Texas Administrative Code §134.1 (f)(1-3) states "Fair and reasonable reimbursement shall:
   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for CPT code 98943 would be a fair and reasonable rate of reimbursement. As a result, payment cannot be recommended.

4. Based upon the submitted explanation of benefits, the respondent denied reimbursement for code 97750-FC based upon reason code "45."

   On the disputed date of service, the requestor billed CPT code 97750-FC.

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

   The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states, "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed."

   28 Texas Administrative Code §134.204(g) states,"The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

   The requestor states in the position summary that "**THE FCE ON 7/22/13 IS REQUIRED, PER THE ODG, TO COMPLETE ASSESSMENT AS THE PATIENT UNDERGOES AND COMPLETES THE PRE-AUTHORIZED PROGRAM. AS IT IS REQUIRED AND MANDATORY, IT HSOULD BE PAID IN FULL"…"Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains."** This means that the ODG requires us to re-evaluate our Pain Management program patients every two weeks while they are in the program."

   The ODG guidelines that the requestor refers to in the position are addressed in 28 Texas Administrative Code §137.100. Review of the documentation submitted finds that the requestor failed to provide the portions of the ODG that related to FCEs and chronic pain management to support its assertion that the service in dispute would be "required" by the ODG. The Division concludes that the requestor's assertion regarding alleged requirement for FCEs is not supported. In addition, the requestor has not shown compliance with any applicable requirements in 28 Texas Administrative Code §137.100(f). For these reasons, 28 Texas Administrative Code §134.204(g) applies to the disputed service.

5. A review of the submitted documentation does not indicate if the disputed FCE is initial, interim or discharge test; therefore, the requestor did not support position that billing was in compliance with 28 Texas Administrative Code §134.204(g). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $233.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $233.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/09/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

.